DITS-SID

MANUAL

Diagnostic Interview Trauma and Stressors - Severe Intellectual Disability

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DITS-SID

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FOREWORD

This manual describes the Diagnostic Interview Trauma and Stressors – Severe Intellectual Disability (DITS-SID), a clinical interview that enables the diagnosis of posttraumatic stress disorder (PTSD) in individuals with severe or moderate intellectual disability (ID[1]) (IQ < 50; severe disabilities in adaptive and cognitive functioning), in accordance with the DSM-5-TR-criteria for children 6 years and younger (American Psychiatric Association, 2022). The DITS-SID is an adapted version of the parent version of the DITS-ID (Mevissen et al., 2018). It is conducted with an informant who knows the individual well, such as a relative, a professional caregiver or another caregiver. Individuals with profound ID have not been included in the DITS-SID validation studies, and some items may not be applicable to them. Nevertheless, the DITS-SID can be conducted to informants of individuals with profound ID, as the DSM-5-TR PTSD criteria ≤ 6 years is expected to be compatible with their cognitive developmental level.

The DSM-5-TR classifies PTSD as a trauma- and stressor-related disorder. The DITS-SID goes beyond the traumatic events and symptoms characteristic of PTSD. The DITS-SID events section includes events that satisfy criterion A (traumas such as exposure to actual or threatened death, serious injury, or sexual or physical violence), as well as a wide range of other stressors, including bullying, out-of-home placement and invasive medical treatment or procedures. This makes the DITS-SID compatible with the broad spectrum of trauma- and stressor-related disorders in the DSM-5-TR.

The DITS-SID comprises a section covering traumatic and stressful events and another covering the symptoms caused by these events. Lastly, the extent to which the individual's daily functioning is impaired by the events they have experienced is determined by the interference score. If the DITS-SID shows an indication for trauma treatment, the timeline (the visual result of the events section) can serve as the basis for treatment.

The DITS-SID is accompanied by the 'DITS-SID Follow-up measurement', intended to reassess symptoms related to previously determined events at a later date, for example to evaluate the effect of a treatment. The section in which the events are asked about has been omitted from the follow-up measurement. However, a question has been added regarding whether any new traumas or stressors have occurred in the meantime.

In recent years, the interview has been validated for use in individuals with severe or moderate ID (Hoogstad et al., 2024 a, c, 2026a). These studies showed that the DSM-5-TR PTSD criteria for young children are largely applicable to this these individuals. There were no indications that the so-called atypical symptoms offer any extra information about the presence of PTSD. However, it does appear that individuals with a severe or moderate ID sometimes show PTSD symptoms that fall under the criteria of older children and adults, and not under those of younger children. In practice, the use of the DITS-SID in both relatives and professional caregivers has yielded positive experiences. The information provided by both categories of informants is generally complementary, and the timeline provides a clear overview of what individuals with severe or moderate ID have experienced. This manual describes the purpose and development of the DITS-SID, the research underlying the DITS-SID, and how the interview should be conducted.

1. In this manual, 'intellectual disability' and 'intellectual disabilities' are abbreviated to 'ID'.

1. INTRODUCTION

In the last fifteen years, considerable expertise has been gained in the recognition and treatment of trauma-related disorders in individuals with mild ID or borderline intellectual functioning. However, until recently, very little was known about trauma in individuals with severe or moderate ID. A review by Mevissen and De Jongh (2010) on the prevalence, assessment and treatment of PTSD in individuals with ID showed that there was little research available in this area. The authors did, however, find indications that individuals with ID are at a higher risk of developing PTSD compared to individuals without ID. At the time, there were no reliable and validated diagnostic instruments for individuals with ID, meaning the prevalence of PTSD in these individuals was unknown. Mevissen and De Jongh partially attributed this to insufficient knowledge on the part of professional caregivers and relatives, and to 'diagnostic overshadowing' whereby PTSD symptoms are interpreted as characteristics of ID. In subsequent years, there has been growing international attention to PTSD in individuals with ID, and more studies have been carried out. These studies primarily concerned individuals with mild ID or borderline intellectual functioning. Research on individuals with severe ID, and to a lesser extent those with moderate ID, lagged behind and valid and reliable diagnostic instruments to classify PTSD in this group were lacking (Hoogstad et al., 2025). Yet, these individuals also experience traumatic events and may develop trauma-related symptoms that require effective treatment.

The need for more knowledge in practice led to the development of the first version of the DITS-SID, a diagnostic instrument to establish PTSD in individuals with severe or moderate ID (Mevissen et al., 2021), thereby contributing to access to trauma-focused treatment and support and helping to prevent unnecessarily prolonged suffering. To this end, we adapted the parent version of the DITS-ID (Mevissen et al., 2018), which was psychometrically valid (Mevissen et al., 2016). We chose the parent version because individuals with severe or moderate ID have (great) difficulty speaking about their experiences, and information usually needs to be obtained from other people. Another reason to choose the parent version of the DITS-ID as a starting point is that the DITS-ID includes the DSM-5-TR[2] PTSD criteria for children 6 years and younger. These criteria correspond best with the cognitive developmental level of individuals with severe or moderate ID.

The DITS-SID has been developed and validated as part of Annemieke Hoogstad's doctoral research on the diagnosis and treatment of PTSD in individuals with severe or moderate ID. The study was conducted at the healthcare organisation Eemhart in collaboration with the Radboud University, the Netherlands. The DITS-SID enables the classification of PTSD in accordance with the DSM-5-TR ≤ 6 years criteria (American Psychiatric Association, 2022). Based on information provided by an informant (a relative, professional, or other caregiver), the interview documents both traumatic and stressful events, asks about symptoms that may result from these experiences, and evaluates the severity and duration of these symptoms.

Although the DITS-SID is primarily aimed at reliably determining a PTSD classification, the description 'trauma and stressors' also emphasises the connection to the broader DSM-5-TR category of trauma- and stressor-related disorders. The interview maps out a wider range of traumatic events than those that satisfy criterion A for PTSD. In addition to documenting PTSD symptoms, the interview also assesses other symptoms, so called atypical symptoms, that can arise following traumatic and stressful events.

In chapter 2, we discuss the validation studies of the DITS-SID and their main findings. Chapter 3 describes the adaptations made in the translation of the parent version of the DITS-ID into the DITS-SID. In chapters 4 and 5, we provide guidelines for the interviewer for conducting and scoring the DITS-SID, as well as the possibility of conducting it online. Subsequently, in chapter 6, we give further information about the use of the DITS-SID Follow-up measurement. In chapter 7, we discuss how the DITS-SID can be used in practice.

2. At the time of the development of the DITS-SID, the revised version of the DSM-5-TR was not yet available. As the criteria of both versions largely correspond and the DSM-5-TR forms the basis of the most recent version of the DITS-SID, the manual refers to the DSM-5-TR.

2. RESEARCH INTO THE DITS-SID

As part of the development of the DITS-SID, its psychometric properties were initially explored in two pilot studies: one involving 26 adults (Hoogstad et al., 2024a) and one involving 15 children (Hoogstad et al., 2024c) with severe or moderate ID. The reliability and validity were then explored in a larger sample of 97 adults (Hoogstad et al., 2026a). In all studies, the DITS-SID was administered, where possible, to both a relative and a professional caregiver. In the first pilot study (Hoogstad et al., 2024a), we administered the DITS-SID to relatives and caregivers of 26 adults (11 men and 15 women). Nineteen adults had severe ID and seven had moderate ID. All the adults lived at Amerpoort (now Eemhart), a healthcare facility for individuals with ID in the Netherlands. The average age was 41,3 years (range: 20-71; *SD* = 15,6). Twenty-five relatives (10 mothers, 5 fathers, 7 siblings and 3 foster mothers), and 26 professional caregivers participated. The relatives had known the individual with severe or moderate ID for an average of 40 years (*SD* = 15,3) and saw them an average of 14,7 hours a week (*SD* = 17,3). Caregivers had known the individual with severe or moderate ID for an average of 6,8 years (*SD* = 6,4) and saw them for an average of 18,8 hours a week (*SD* = 9,4). Due to COVID-19 restrictions, trained interviewers conducted the interviews online. All interviews were recorded on video to determine interrater reliability, which could not be determined in six interviews due to technical problems. The remaining 45 interviews were reassessed per item by an independent second assessor. We calculated both Cohen's kappa and the percent agreement. The reliability was good for the PTSD classification (present/absent) (κ = .73; agreement = 93%; Cicchetti, 1994), and for the majority of the event and symptom items, it was good to excellent (κ = .60–1.00; agreement = 73–100%). Criterion A had a good to excellent reliability (κ = .66–1.00; agreement = 84–100%). Conducting the interview online was not a problem for any of the relatives or caregivers. Even though discussing traumatic and stressful events proved emotionally difficult for several of the relatives, all DITS-SID interviews were completed in full.

In the second pilot study (Hoogstad et al., 2024c), we administered the DITS-SID with fifteen mothers of seven girls and eight boys aged between 9 and 17 years, with an average age of 13,1 years (*SD* = 2,7). Thirteen of these children had severe ID and two had moderate ID. Nine children lived in a healthcare facility, and in their case, a professional caregiver was also interviewed. The caregivers had known the child an average of 1,2 years (*SD* = 2,4) and had an average of 27,8 hours (*SD* = 4,7) of contact with the child per week. Naturally, the mothers had known their children their whole lives (*M* = 14,2 years; *SD* = 2,7) and spent an average of 19,8 hours per week (*SD* = 18,3) on direct care and contact. Two trained interviewers independently assessed each item across all 24 interviews. The reliability for the PTSD classification was excellent (κ = 1.00; agreement = 100%). The reliability of the event and symptom items was good to excellent (κ = .60–1.00; agreement = 79–100%). Criterion A also had excellent reliability (κ = .83–1.00; agreement = 88–100%). In this study too, all interviews were completed in full.

Subsequently, the DITS-SID was examined in a sample of 97 adults with severe (49 adults) and moderate (48 adults) ID (Hoogstad et al., 2026a): 47 women and 50 men. The average age was 41,3 years (range 18-90; *SD* = 17,4). The adults lived in a number of different residential healthcare facilities for individuals with ID in the Netherlands. Eighty participants had at least one co-occurring diagnosis (including autism spectrum disorder, epilepsy, Down's syndrome, Rett or Dravet syndrome and visual impairment). No relatives were able to participate for 19 adults. For three of them, a mentor who had known them for many years was able to participate (range 15–56). The population of 81 relatives comprised 38 mothers, 10 fathers, 21 siblings, 2 aunts, 2 sisters-in-law, 1 foster mother, 1 stepmother and the 3 mentors. At their own request, three interviews were carried out with two relatives at the same time (twice with a mother and a father, and once with a mother and a cousin). The average age of the relatives was 38,2 years (*SD* = 17,0; range 15–76), and they spent an average of 8,6 hours a week (*SD* = 11,4; range 0–72) in contact with the individual with a severe or moderate ID. A total of 96 professional caregivers took part. They had known the individual with severe or moderate ID for an average of 6,1 years (*SD* = 16,9; range 0,5–34), and had an average of 21,2 hours (SD = 11,4; range 3–40) of contact a week. Thirty percent of the interviews (23 with relatives, 30 with caregivers) were reassessed independently by seven trained researchers. To establish the interrater reliability, we calculated Gwet's AC1, as Cohen's kappa can be misleadingly low if the distribution is uneven. The interrater reliability was excellent for both the PTSD classification (κ = .79 for relatives; κ = 1.00 for caregivers) and for criterion A (Gwet's κ = 1.00 for relatives; κ = .87 for caregivers). All values for event and symptom items were above 60, indicating good to excellent reliability.

In all three studies, convergent validity was supported by a strong, positive correlation between DITS-SID PTSD symptoms measured by the *Kind en Jeugd Trauma Screener 3-6 jaar* (The Dutch Child and Adolescent Trauma Screener 3-6 Years; Kooij & Lindauer, 2019), and by a moderate to strong positive correlation with problem behaviour measured by the Aberrant Behavior Checklist (Aman et al., 1985).

Below are the main findings of the study involving 97 adults with severe or moderate ID concerning the content validity and how PTSD manifests:

- Based on the informants' reports, individuals who met the PTSD symptom criteria experienced a higher average level of daily suffering (as measured by the DITS-SID interference thermometer) than those who did not meet the criteria.

- Informants reported a higher average number of traumatic and stressful events for individuals who met the PTSD symptom criteria. This aligns with the cumulative effect of traumas and stressors, in which multiple traumatic events can amplify one another, strengthening their overall impact and increasing the risk of developing PTSD (Kira et al., 2021).

- Individuals who met the DSM-5-TR criterion A did not meet the PTSD symptom criteria more often than those who did not meet criterion A. This may partly reflect underreporting of criterion A events: individuals with severe or moderate ID are not always able to verbalise what they have experienced, meaning some traumas may be unknown to the informants and therefore not mentioned during the DITS-SID interview. Conversely, stressful events that do not meet criterion A may still lead to PTSD symptoms in these individuals, for example invasive medical treatments or procedures.

- The DSM-5-TR ≤ 6 years symptom criteria appear to be broadly applicable, but are unlikely to be entirely suitable for individuals with severe or moderate ID. Two of the most often reported PTSD symptoms (i.e., self-harm and lower levels of trust in others) do not fall under these criteria, while they are included in the criteria for older children and adults.

- Although the psychometric properties were comparable for relatives and professional caregivers, agreement on the presence of a PTSD classification was low. This is not unusual, as individual informants observe different aspects of symptoms and functioning (De Los Reyes et al., 2013). These differences can complement one another in the diagnostic process.

- Before the DITS-SID was conducted, the psychologist involved was asked which diagnoses had been established for the individual with severe or moderate ID. None of the individuals with severe or moderate ID were identified as having PTSD, whereas in the study of 97 adults, 20% received a PTSD classification based on the DITS-SID according to at least one of the two informants. By way of comparison: the likelihood of PTSD ever occurring in the lives of individuals without an ID is 11% (Hoeboer et al., 2025), and, based on DITS-ID interviews, this is 38–58% in individuals with mild ID or borderline intellectual functioning (Mevissen et al., 2020, Versluis et al., 2025). However, it is possible that symptoms and traumatic events were missed in the study of 97 adults with severe or moderate ID. Due to their limited verbal communication skills, they cannot communicate all of the experiences they have had or the symptoms they are experiencing. In addition, internalizing symptoms such as re-experiencing (criterion B), and avoidance or negative changes in cognition and mood (criterion C), are difficult to observe for both relatives and caregivers (Kildahl et al., 2020; Rittmannsberger et al., 2019).

3. FROM DITS-ID TO DITS-SID

3.1 DEVELOPMENT OF THE DITS-SID

During the development of the DITS-SID, two rounds of adaptations were carried out: one in 2021, before the validity and reliability studies, and one in 2025, after their completion. The adaptations made in the first round, during which the parent version of the DITS-ID was adapted for individuals with severe or moderate ID, were based on the following steps (see Hoogstad et al., 2024a):

1. Eleven psychologists with at least two years of experience treating trauma in individuals with severe or moderate ID completed a questionnaire assessing the extent to which each item in the parent version of the DITS-ID was applicable to these individuals. There was also an open question regarding which events or symptoms they thought were missing;

2. Events and PTSD symptoms from diagnostic measurements (no older than 20 years) used to classify or screen for PTSD in children aged six years and younger were reviewed, and the similarities and differences were analysed;

3. Based on the two steps described above, the relevant literature and the authors' clinical experience, it was assessed whether items needed to be adapted or added.

Among other things, the adaptations included the rephrasing of several items, the addition of an event and symptom item and an open symptom item. No items were removed at that time, as there was still a need to determine which items were rarely reported. Prompted by the results of the validation study involving 97 individuals and the experiences of the researchers who conducted the DITS-SID, a further round of adaptations was carried out in 2025. This resulted in the addition of two event items, further rephrasing and the removal of some items.

3.2 ADAPTATIONS

The following adaptations have been implemented in the DITS-SID compared to the parent version of DITS-ID:

- Several items have been reworded to make them more applicable to individuals with severe or moderate ID. These adaptations particularly concerned items on the living situation (e.g., the addition of 'daycare' to 'school' or 'work'). The following phrase has been added to several items: 'Or has *(name)* seen or heard that this happened to a parent or a caregiver?' as the DSM-5-TR PTSD ≤ 6 years criteria emphasise that seeing or hearing that a primary caregiver has experienced such events can be traumatising for young children. The same applies for individuals with severe or moderate ID who are highly dependent on parents, family members and healthcare professionals.

- Two events have been added. As medical conditions such as reflux, epilepsy, spasticity or swallowing disorders are common among individuals with ID and tend to be more severe with increasing levels of disability (Folch et al., 2019), we have added an event that refers to these conditions. We have also added an event that addresses the permanent departure of a trusted caregiver or the experience of frequent changes among trusted caregivers (Friedman, 2021). Individuals with severe or moderate ID are highly dependent on regular caregivers and often live in residential care, which can make such changes particularly impactful.

- The content of three events has been adapted. (1) Because individuals with severe or moderate ID are rarely found within prison populations (Edberg et al., 2022; Hellenbach et al., 2017), we changed the item "Has *(name)* ever been in prison, or has someone they know very well ever been in prison?" to: "Has anyone who (name) knows very well been in prison?" (2) Experiencing situations in which individuals with severe or moderate ID have exhibited aggressive behaviour themselves, such as attacking others, occurs relatively

often (Bowring et al., 2017). As the existing items did not explicitly enquire about this, and such an event was mentioned several times in the open events item, we have added the following to item 10 ('Has *(name)* ever witnessed someone being threatened or abused (e.g., hitting, kicking, shooting, stabbing, grabbing by the throat)?'): "Or has (name) ever physically attacked someone?" (3) We added the following to item 9 (see text in italics): "Has anyone ever done anything else to *(name)*, or forced *(name)* to do something that they really did not want to do? *For example, experiencing physical restraint*? Or has (*name*) seen or heard that this happen to *someone else*?"

- Individuals with severe or moderate ID differ in their ability to communicate what they are experiencing. For this reason, to those items that require some communication skill, we have added: "If (*name*) is able to express this,…" or, to one item: "If (*name*) can speak,…". This concerns the following items (the first three of which count for the DSM-5-TR PTSD ≤ 6 years, additions in italics):
  - **Item 34:** "*If (name) is able to express this*, does *(name)* often complain about having thoughts about one or more events that he/she does not want to have?"
  - **Item 36:** "*If (name) is able to express this*, does *(name)* complain about hearing voices in his/her head related to the events?"
  - **Item 46:** "*If (name) can speak*, does *(name)* do their best to avoid speaking about the events?"
  - **Item 47:** "*If (name) is able to express this*, does *(name)* report being unable to remember certain important aspects about the events, as if these have disappeared from their memory?"
  - **Item 53:** "*If (name) is able to express this*, have you noticed that *(name)* has negative thoughts about himself/herself more often since the events, such as believing they are a bad person and not worthwhile?"

Although items 47 and 53 do not contribute to a PTSD classification according to the DSM-5-TR ≤ 6 years criteria, they have been retained in the DITS-SID because they were frequently endorsed ('Yes') in the study involving 97 individuals with severe or moderate ID.

- The item "Does (*name*) make a strong effort not to think about the events?" has been removed. The item measures an internalised cognitive avoidance process that is scarcely reflected in observable behaviour, making it difficult for informants to assess this symptom. In the validation study, the item was relatively often answered with "Don't know". Moreover, this item does not contribute to a PTSD classification according to the DSM-5-TR ≤ 6 years criteria.

- The item "Do you notice that (*name*) feels that the future has little to offer them?" has been removed. This item requires a level of future-oriented thinking and self-reflection that is not realistic or feasible for individuals with severe or moderate ID. In the validation study, informants rarely endorsed this item, particularly for individuals with severe ID. In addition, this item does not contribute to a PTSD classification according to the DSM-5-TR ≤ 6 years criteria.

- The open symptom item has been removed. Most of the reported symptoms fell under existing items, while the few responses that could not be classified within other DITS-SID items were mentioned only once.

3.3 REVIEW ROUNDS

The DITS-SID (manual, interview and score form) has been reviewed by eight psychologists, and one psychodiagnostic worker. All professionals involved had experience in the diagnosis and/or treatment of PTSD in individuals with severe or moderate ID, or had substantial general experience in working with these individuals. The DITS-SID has also been reviewed by a policy and communications officer. The professionals involved evaluated the manual to determine whether it is comprehensible and whether the instructions were clear and feasible.

4. CONDUCTING THE DITS-SID

4.1 INTERVIEWER QUALIFICATIONS

The DITS-SID is intended for healthcare professionals with diagnostic competence and expertise in psychopathology, such as clinical psychologists, neuropsychologists, educational psychologists, child and adolescent psychologists, or psychiatrists. It is important that the interviewer has undergone training in conducting the interview in accordance with the manual, or that the interview is conducted under the supervision of a trained and experienced interviewer who provides feedback on the interview and its assessment. It takes practice to conduct the interview efficiently (within one hour) while also following the guidelines and ensuring the informant does not become emotionally unsettled. For example, without training, there is a high risk that the interviewer will ask for irrelevant details about events and fails to ask for the specific information needed to assess whether the DSM-5-TR criteria for a traumatic event are met. An interviewer who uses the DITS-SID solely as grounds for trauma treatment (see Section 7) may place different emphases than an interviewer whose primary goal is to establish a PTSD classification in accordance with the DSM-5-TR.

4.2 THE DITS-SID INFORMANT

Because individuals with severe or moderate ID are (very) limited in their ability to speak of their experiences and feelings, the DITS-SID is conducted with an informant who knows the individual well. In this way, as complete a picture as possible is obtained of traumatic events and their associated symptoms in daily life. If possible, the interviewer should conduct the DITS-SID with a relative (e.g., parents or siblings) and a professional caregiver. Professional caregivers often mainly know the life history of the individual with severe or moderate ID from their case files, but the individual's history of trauma is by no means always explicitly described there. Nevertheless, professional caregivers also see the individual with severe or moderate ID in a different context than relatives, meaning they observe other events or symptoms than the relatives. The different types of information gained from relatives and professional caregivers therefore supplement each other. As a result, the DITS-SID provides an overview of the traumatic events which relatives and professional caregivers know the individual with severe or moderate ID has experienced. It also clarifies the symptoms that the individual with severe or moderate ID has developed, according to their relatives or caregivers, and the extent to which these symptoms are impeding their functioning. The interviewer must bear in mind that the interference score is partially an estimation of how the individual with severe or moderate ID may experience the impact of the events. Furthermore, the information identified using the DITS-SID may not be complete, as the individual with severe or moderate ID may have experienced events that relatives or caregivers are unaware of.

4.3 INSTRUCTIONS FOR CONDUCTING THE DITS-SID

4.3.1 General

Instructions for the informant

The interviewer should follow the instructions as written and preferably does not use their own wording. The question should be rephrased if the interviewer notices that, despite repeating the question, the informant either does not understand or misunderstands a question. For example, if an informant answers the question "Has (*name*) ever been touched somewhere on their body by someone, when they really did not want that?" by saying that another individual with ID pulled their hair, you could say: "I mean a different sort of touching. Has anyone ever touched (*name*) in a sexual way, when they really did not want that?" Another example of simplification is to split questions 17 and 18 into shorter questions. For question 17 ("Has (*name*) ever been very ill, has he/she been in hospital or had an unpleasant medical examination or treatment from a doctor or a dentist, for

example?"), the interviewer could ask, "Has (*name*) ever been very ill?", "Has (*name*) ever had an unpleasant examination or treatment from a doctor?", "Has (*name*) ever had unpleasant examinations or treatments from a dentist?". Use the 'DITS-SID Additional events' if there are multiple events (see page 18 of the DITS-SID interview).

Attitude
The interviewer shows understanding of any emotions expressed by the informant (e.g., "I understand that this is difficult for you"), but maintains a professional and neutral attitude during the interview.

Answer categories
The interviewer uses the answer category 'Other' if the informant answers along the lines of: "I don't know", "(*name*) has always been like that" or "(*name*) can't do that because (*name*) can't talk/ isn't at that level" or gives an unclear answer. The interviewer notes the answer.

When asking questions about symptoms, the interviewer is alert to nuances in severity or frequency. For example, items 34, 35 and 39 ask whether the individual "often" suffers from the symptom concerned. If the answer is "Sometimes" or "now and again", the interviewer ticks 'Other' and notes the answer. If there is no mention of the frequency or severity of the symptom in the question and the informant answers "Sometimes", then the interviewer ticks 'Yes'. In this case, it is alright to tick 'Yes', even if the individual only sometimes has the symptom. If the answer is: "They used to but not anymore" then the interviewer ticks 'Other' and notes the answer.

When introducing the section on symptoms, the interviewer explains that this concerns changes since the events. This can cause confusion in individuals who have experienced traumatic and stressful incidents since birth. If this is the case, the interviewer asks the informants if they recognise or suspect a connection between the symptoms that the individual with severe or moderate ID has experienced, and then scores it on that basis. If there is no clear 'Yes' or 'No', the interviewer ticks 'Other' and notes the answer (e.g., "I don't know").

Question 56 ("Have you noticed that (*name*) can no longer feel happy since the events?") may cause confusion due to the negation it contains. If the informant says "(*name*) can still feel happy", the interviewer ticks 'No'.

The 'Other' answers are not counted in the scoring but may well provide clinically relevant information. For example, if the individual has always had concentration problems and may have AD(H)D.

4.3.2 Traumatic and Stressful Events

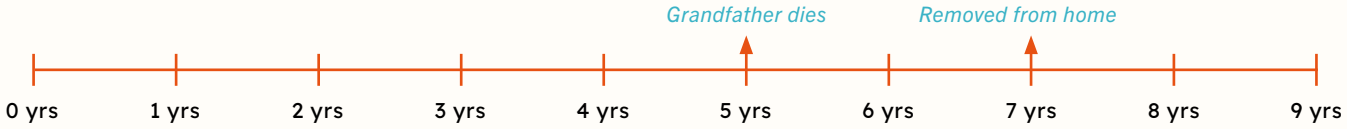
Collecting information
In the 'Traumatic and stressful events' section, the interviewer first asks what has happened. The interviewer aims to obtain enough information to be able to assess whether the event meets criterion A for trauma of the DSM-5-TR (see page 305-306; American Psychiatric Association, 2022). The interviewer must keep this as brief as possible to avoid the possibility of the informant becoming too upset by negative feelings that may be associated with memories of the event. The interviewer must be aware that relatives or caregivers may also have been victims of the same event(s), or that they have seen or heard what happened to the individual with severe or moderate ID, and that they may be shocked by their reactions. However, if the interviewer maintains a professional and neutral attitude, the risk of dysregulating relatives or caregivers is small. The risk of dysregulation remains low if, when the informant speaks at length about the events, the interviewer explains that the purpose of the DITS-SID is not to go into detail on the events for too long, in order to prevent any distressing feelings from becoming too overwhelming.

Establishing a timeline
The interviewer asks how old the individual was when the event took place; this age is recorded. The interviewer then shows the 'Timeline'. The beginning of the line represents birth. The interviewer places the current age of the individual with severe or moderate ID at the far right of the line and divides the line up into segments of equal length. The number of segments should correspond with the age of the individual with severe or moderate ID. If the individual is over the age of 25, the interviewer should divide the timeline into segments of 5 years. The interviewer asks or discusses with the informant what name to use for the event. The interviewer then marks the event in the correct

place on the timeline. If the informant does not know the exact age of the individual at the time of the event, the interviewer asks them to point to the place on the line where the event should be placed. If necessary, the interviewer asks about the location of one event on the line in relation to another event, e.g., "Which happened first, … or …?" The interviewer ensures that the events appear on the timeline in the correct chronological order. If the informant does not know the order in which the events took place, the interviewer will write down the events above the timeline without connecting these to the timeline.

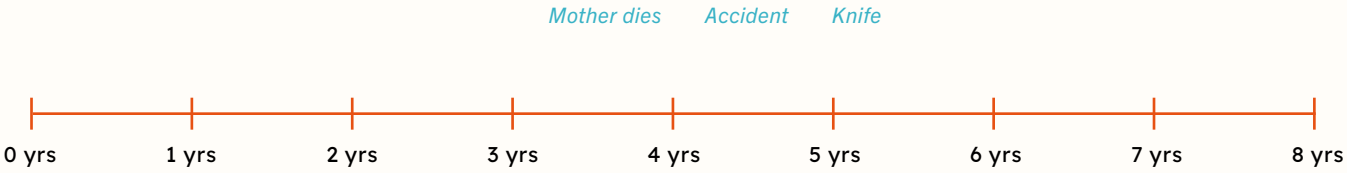
EXAMPLE 1

Jake is 9 years old. When he was 5, his grandfather died, and when he was 7, he was placed in out-of-home care.



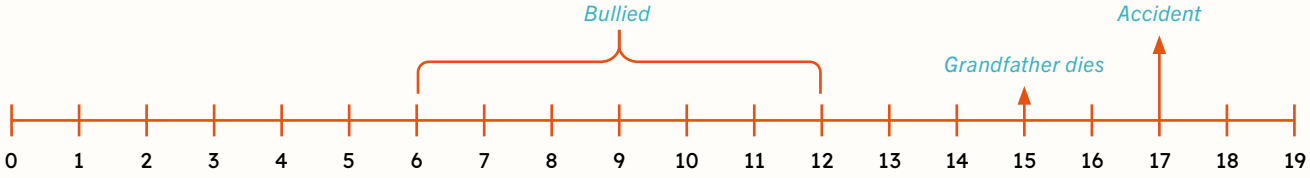
EXAMPLE 2

Mia is 8 years old. She has been involved in a serious accident, her mother has died and she has witnessed a stabbing. The informant does not know how old Mia was when these things happened, but can provide the order in which the events occurred.



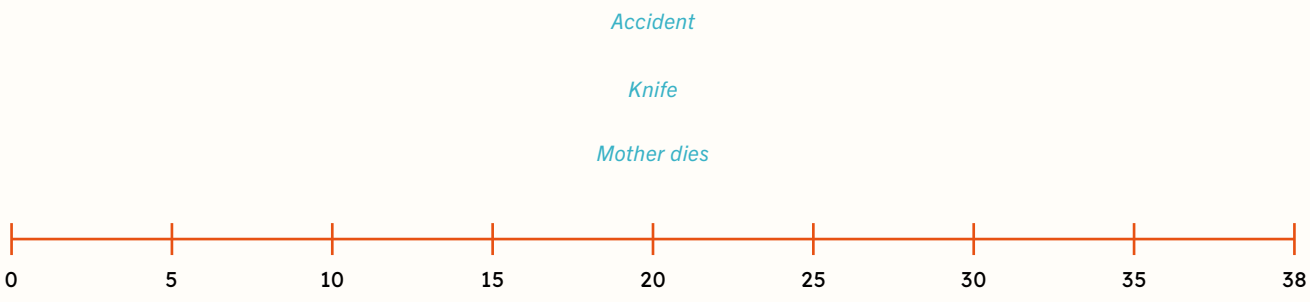
EXAMPLE 3

Peter is 19 years old. He was bullied between the ages of 6 and 12 (frequently subjected to verbal abuse). His grandfather died when he was 15, and he was involved in an accident at 17.



EXAMPLE 4

Sabine is 38 years old. She was involved in a serious accident, her mother has died and she has witnessed a stabbing. The informant cannot indicate how old Sabine was when these events occurred, and does not know what happened first.



Visual support
The interviewer uses as few words as possible to describe each event so that the timeline remains easy-to-read, and continuously checks whether the informant can read the interviewer's handwriting (or, if the timeline is digital, the typed entries). This is important because the timeline is used as a visual support when exploring the symptoms and the interference score.

Additional events
If the informant spontaneously mentions more than one event (e.g., the individual with severe or moderate ID has been involved in more than one accident, or has been confronted with the death of a loved one more than once), the interviewer uses the appendix 'DITS-SID Additional events' and deals with each of the events sequentially.

Previously mentioned
If the informant has already mentioned a relevant event while answering a previous question and this has already been noted by the interviewer, then tick 'Yes' and write: "See question (x)". For example: The informant mentioned abuse in question 1 (open question). Then, next to questions 6 and/or 7 and/or 12, the interviewer ticks 'Yes' and notes 'See question 1'. When asking the relevant question/questions, the interviewer enquires if the individual with severe or moderate ID has had any similar experiences. If the answer is 'Yes', the interviewer notes this in the 'DITS-SID Additional events' appendix.

4.4 INSTRUCTIONS FOR CONDUCTING THE DITS-SID ONLINE

The DITS-SID can also be conducted online via a video call. In the validation studies into the DITS-SID mentioned earlier (Hoogstad et al., 2024a,c, 2026a), only a small number of informants opted for an in-person interview. An online interview did not pose an obstacle. The online interview follows the same sequence and instructions as an in-person interview. The main difference is that the timeline and the thermometer are completed and shared online rather than in a physical format. It is recommended that all the necessary documents be opened prior to the interview: the DITS-SID interview, the timeline document and the thermometer document. The interviewer positions the interview and the video call next to each other on the screen so that the interviewer can see both the questions and the informant (neither window should fill the whole screen). As with an in-person interview, the informant does not see the interview questions; the interviewer does not share the DITS-SID interview window with the informant. Most video-conferencing platforms offer the option to share individual windows, although the functionality varies by programme. It is recommended to verify this in the relevant platform in advance.

For digital administration, a timeline can be created using digital software, such as a drawing program or Word. In our study (Hoogstad et al., 2026a), the use of Word[3.] was chosen. If the informant answers an event item with "Yes" and the interviewer has explored what happened, the interviewer shares the window containing the timeline with the informant. The interviewer enters the age of the individual with severe or moderate ID on the right-hand side of the timeline. In consultation with the informant, the event is assigned a name and is placed appropriately on the timeline. If it involves a period of events, the interviewer places these above the timeline, just as in an in-person interview. The interviewer then verifies that the informant can read everything clearly. The interviewer subsequently stops sharing the timeline window and continues to the next event question.

During the assessment of the PTSD symptoms (items 34 to 74), the interviewer once again shares the timeline window and keeps it visible to the informant while asking about the symptoms. In the instruction preceding item 34, the interviewer explains that the questions pertain to all events on the timeline, as these cannot be pointed at like in an in-person interview. After the first two prompts in item 75 (Interference), the interviewer stops sharing the timeline and shares the thermometer window instead. At item 76 (Duration of symptoms), the interviewer closes the thermometer window and reshares the timeline window with the informant.

3. A template for a digital timeline in Word is available via the DITS-SID website of Eemhart.

5. SCORING THE DITS-SID

Below are the steps the interviewer follows when completing the score form.

1. The interviewer first determines whether the individual with severe or moderate ID has experienced one or more events that meet criterion A for PTSD for 6 years and younger. The score form provides a brief outline of the relevant A-criterion. Criterion A concerns exposure to a traumatic event whereby there is actual or threatened death, serious injury, or physical or sexual violence. This exposure can take various forms: personally experiencing the event, witnessing it in others, especially primary caregivers, or learning that such an event has happened to a parent or caregiver. The DSM-5-TR provides further clarification of Criterion A on pages 305–306. For example, sexual trauma covers all forms of actual or threatened sexual violence or force, including forced sexual penetration, but also sexual experiences without physical contact, such as forced exposure to pornography or showing of genitals. For children, sexual experiences without physical violence or injury fall under criterion A if they are developmentally inappropriate. Experiences of bullying fall under criterion A if there is also a threat of or actual severe physical injury or sexual violence. A serious medical or physical condition does not automatically qualify as a traumatic event; this is only the case if it involves an acute life-threatening situation or medical intervention that is linked to intense fear, pain, helplessness or fear of death. Witnessing a traumatic event includes witnessing actual or threatened serious injury, unnatural death, physical or sexual abuse, domestic violence, a serious accident, war or disaster. The DSM-5-TR description on learning about a traumatic event (criterion A3) does not differentiate between young children, and older children and adults. As stated above, the criteria for young children, as included in the DITS-SID, relate to learning about traumatic events that have happened to parents or caregivers. If the interviewer is unsure whether an event meets the A-criterion, they should consult the DSM-5-TR text for further clarification (American Psychiatric Association, 2022, pages 305-306).
2. The interviewer moves to the second column, 'Corresponding interview question', and ticks the questions that were answered 'Yes' in the events section of the DITS-SID for symptoms B1 through D5.
3. The interviewer assesses, for each of the criteria B, C and D, whether the criterion is met in accordance with the guideline presented in the third column, and then ticks 'Yes' or 'No' in the fourth column.
4. The interviewer indicates under section E whether the symptoms have been present for more than one month ('Yes' or 'No').
5. The interviewer determines whether the interference score F is 4 or higher ('Yes' or 'No').
6. Criterion G states that the symptoms may not result from substance use or a medical condition. Because the relationship between the symptoms and the event(s) on the timeline is explicitly addressed, we assume that this question can be ticked 'Yes'.
7. The interviewer determines whether a PTSD classification can be established by verifying that criteria A to G are met (7x 'Yes'), and subsequently ticks 'Yes' or 'No'.
8. The interviewer may also wish to further specify the presence of dissociative symptoms by determining whether questions 59 or 60 of the DITS-SID have been answered 'Yes'.

The DSM-5-TR also requires the interviewer to specify whether the complete PTSD pattern of symptoms is met at least 6 months after the event ('with delayed expression'). This cannot be determined on the basis of the DITS-SID. The above does not affect the decision as to whether PTSD is present, nor does it influence any referral for treatment. If dissociative symptoms or delayed expression are present, the interviewer may note this in the diagnostic report.

Not every symptom in the DITS-SID counts towards a DSM-5-TR PTSD ≤ 6 years classification, such as self-harm and lower levels of trust. In that case, these symptoms can be noted in the DITS-SID interview report, so they are included in the evaluation of the severity of the symptoms of the individual with severe or moderate ID.

6. DITS-SID FOLLOW-UP MEASUREMENTS

In clinical practice, it is often important to check whether there have been any changes in the symptoms over time, for example to evaluate the outcome of treatment. To that end, a modified document has been developed: the 'DITS-SID Follow-up measurement'. As the experienced events were inventoried and placed on the timeline during the first interview, the 'events' section has been omitted from the follow-up measurement. The same timeline is used during the Follow-up interview. Because the individual with severe or moderate ID may have experienced one or more traumatic events since the first DITS-SID interview and this may have influenced the current pattern of symptoms, the 'DITS-SID follow-up measurement' begins with an open question on this topic. If, during the intervening period, the individual with severe or moderate ID has experienced one or more traumatic events, the interviewer will add these events to the timeline and confirm that the informant can read them. The interviewer uses this updated timeline when further enquiring about the symptoms and the interference score, and then completes the score form in the usual way.

The interviewer follows the procedure described above for each follow up measurement to ensure that the symptoms and the interference score are always discussed using an updated timeline.

The 'DITS-SID Follow-up measurement' is also a valuable tool for scientific research into the assessment and treatment of trauma- and stressor-related disorders in individuals with severe or moderate ID. This may include follow-up research into the effectiveness of EMDR therapy and studies into other treatment modalities for trauma in these individuals, such as exposure therapy.

7. DITS-SID: APPLICATION IN PRACTICE

7.1 USING THE DITS-SID WITH RELATIVES OR CAREGIVERS

Conducting the DITS-SID gives the interviewer an impression of the relatives' and caregivers' own experiences. They may have been victims or witnesses of the same event(s) that the individual with severe or moderate ID has experienced. They may have learned about what happened to the individual with severe or moderate ID, and may have been shocked by their reactions. Another possibility is that the traumatic event that happened to the individual with severe or moderate ID triggers the relative's or caregiver's own previous traumatic experiences. In these situations, relatives or caregivers can also develop posttraumatic stress, which can amplify the symptoms of the individual with severe or moderate ID. This may result in a so-called 'stress-enhancing parenting or caregiving style', in which relatives or caregivers overprotect the individual with severe or moderate ID, inadvertently frighten them, or are emotionally and physically unavailable to them. Such situations may occur in cases of sudden death or serious illness of a loved one, a natural disaster, experiences of bullying, physical violence, medical trauma, domestic violence, a serious accident or sexual abuse. In addition, severe behavioural problems in individuals with severe or moderate ID can also be distressing or damaging for relatives or caregivers. Examples include aggression, self-injury or eating disorders. It is strongly recommended to take information about possible traumatisation of relatives or caregivers into account when providing advice on further diagnostics and treatment. It is also important to discuss the results of the interviews jointly with the parties involved, provided that the legal representative of the individual with severe or moderate ID and the informants (relatives and caregivers) give their consent. Sharing negative experiences can contribute to the healing process. For background information on a systemic approach to the diagnostic assessment and treatment of trauma-related symptoms, we refer the reader to Hoogstad and colleagues (2026c).

7.2 THE DITS-SID AS A BASIS FOR TREATMENT OF TRAUMA- AND STRESSOR-RELATED SYMPTOMS

Within the DSM-5-TR diagnostic framework, PTSD is classified under the category 'Trauma- and stressor-related disorders'. A common characteristic of these disorders is that exposure to a traumatic or stressful event is an unconditional diagnostic criterion. In addition, the DSM-5-TR states that there is a close connection between these disorders and anxiety disorders, obsessive-compulsive and related disorders, and dissociative disorders. The DITS-SID provides an overview of symptoms, which, according to the informant, originate from the events that the individual with severe or moderate ID has experienced. These may be other combinations of events and symptoms than only those of PTSD. PTSD symptoms often overlap with symptoms associated with other disorders, such as mood or anxiety disorders. The DITS-SID also contains a few atypical symptoms, such as eating disorders and compulsive or stereotypical behaviour that does not fall under the DSM-5-TR criteria for PTSD, but which, according to the literature, can occur in individuals with ID following traumatic or stressful experiences.

If the DITS-SID results indicate a PTSD-classification, a referral can be made for a first-choice treatment for PTSD. Two therapies are internationally acknowledged to be evidence-based and first-choice for the treatment of PTSD: Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) and Eye Movement Desensitisation and Reprocessing (EMDR) therapy (World Health Organization, 2023). EMDR therapy can be used to treat individuals with severe or moderate ID (see Byrne, 2022). The EMDR storytelling method is a good option for this these individuals, as it was originally developed for very young children and for individuals who are unable to verbalise their traumatic experiences. For individuals with moderate ID, a combination of the storytelling method and the standard EMDR protocol for children can be used, where appropriate and feasible (see Beer & De Roos, 2026). If possible, the standard EMDR protocol for children may also be used on its own. EMDR therapists are trained in the EMDR story method as part of accredited EMDR training programmes. Requirements for training and accreditation may vary by country.

The EMDR storytelling method activates traumatic memories by reading a story out loud, sometimes accompanied by objects or pictures. The therapist and a trusted caregiver create the story. While the story is being read out loud, the individual is given a task to distract them; this could be tactile or auditory. The EMDR storytelling method has not been studied as much as the standard EMDR protocol, but the available studies show positive results. After the EMDR storytelling method was applied, PTSD symptoms diminished in children (De Roos et al., 2025; Olivier et al., 2022; Potharst et al., 2024) and in individuals with severe ID (Barol & Seubert, 2010; Hoogstad et al., 2024b, 2026; Mevissen et al., 2012). In some of these studies, emotional and behavioural problems and parental childrearing stress were also found to decrease.

Referral for trauma treatment is also possible if the DITS-SID indicates that someone has developed symptoms due to traumatic events, but does not meet the PTSD classification criteria. EMDR therapy is not only intended for the treatment of PTSD, but also for other forms of psychopathology in which the symptoms are partially or fully driven by unprocessed traumatic and other negative life events (Shapiro, 2018). Research into the broader application of EMDR therapy is currently in development (Matthijssen et al., 2020). EMDR therapy has shown positive effects across various conditions in individuals without ID, including somatoform disorders, eating disorders, mood disorders, anxiety disorders, obsessive-compulsive disorders, pain and sleep problems (Scelles & Bulnes, 2021). Based on the results of randomised controlled trials (RCTs) in children, EMDR therapy has shown significant improvements in self-image and behavioural problems (Wanders et al., 2008), as well as a significant reduction in symptoms in children with a behavioural disorder (Soberman et al., 2002). A pilot study has shown EMDR therapy to have positive effects on the attachment relationship between parent and child (Wesselmann et al., 2012). Additionally, research in adolescents suggests that EMDR therapy has positive effects on symptoms of depression (Paauw et al., 2019). In adults, EMDR therapy also appears to be applicable for a wide range of psychological complaints, including panic disorders (Horst et al., 2017), self-harm (Griffioen et al., 2017), symptoms of depression (Behnammoghadam et al., 2015; Hase et al., 2015, 2018; Ostacoli et al., 2018; Seok & Kim, 2024), adjustment disorders (Cvetek, 2008) and chronic pain (Driessen et al., 2024).

When individuals with severe or moderate ID are referred for further diagnosis and treatment for emotional and behavioural problems, the DITS-SID can highlight the part of the problem that is related to exposure to traumatic and stressful events. The distressing memories can then be processed using EMDR therapy. Future research in individuals with severe or moderate ID should show whether EMDR is effective in forms of psychopathology other than PTSD.

An example

In the case of Eva, a girl with severe ID, it became clear after conducting the DITS-SID that her overwhelming fear of thunderstorms, rain and wind had developed years ago after experiencing severe weather while on holiday. Her fear was gone after two EMDR therapy sessions, and she was still symptom-free at a follow-up appointment nine months later. She fell asleep easily and slept through the night. As she no longer panicked, her parents felt confident leaving her with a babysitter and considered it safe for Eva to stay overnight with family. This gave them the opportunity to regularly take a break. The quality of life for both Eva and her parents was better after the EMDR treatment.

7.3 THE DITS-SID AS AN AID TO THE EMDR STORYTELLING METHOD

Because the DITS-SID offers an extensive, chronological overview of experienced events and their related symptoms, it can be useful in working with the EMDR storytelling method. In this method, events that are thematically connected, such as unpleasant medical experiences or domestic violence, are written in the form of a story, generally in chronological order. Using the DITS-SID timeline as a guide, the EMDR therapist and caregivers can determine which events are included in a trauma story and the order in which the trauma stories should be developed and treated.

The DITS-SID can also be used after all the trauma stories have been treated. The therapist can conduct a DITS-SID Follow-up measurement with the caregivers to reassess the symptoms, and then, in consultation, determine whether further action is required. If the follow-up assessment reveals that there are still residual symptoms thought to be related to traumatic or stressful events that have not yet been sufficiently processed, memories of these events can be further treated using the storytelling method.

CONCLUSION

The DITS-SID provides a structured and well-founded measurement for classifying PTSD in individuals with severe or moderate ID, in accordance with the DSM-5-TR PTSD ≤ 6 years criteria. This manual offers insight into the background and development of the DITS-SID, the methods used to examine the DITS-SID, and how the interview should be conducted. The DITS-SID has a broader applicability than the classification of PTSD alone. It can also be used to identify other symptoms that have arisen after traumatic or stressful events. The DITS-SID can also help assess caregivers' support needs. Additionally, the DITS-SID can assist in working with the EMDR storytelling method. Given the increased risk of developing PTSD among individuals with severe or moderate ID, the DITS-SID makes an important contribution to timely recognition and targeted treatment of this vulnerable group.

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